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ABSTRACT

The report describes the clinical findings of a collaborative program to provide appropriate neuropsychiatric skills for 60 children ages 8 to 14 (grade 3 to 8) and their teachers. The children represented the entire population of two self-contained units (eight classes) for the treatment of children designated as severely emotionally handicapped but not autistic. Of the 60 children, 36 (60%) were suffering from learning disabilities. Eighteen of these had neurological signs suggestive of organic defect of the central nervous system; the remaining 18 children with learning disabilities had specific or developmental learning disabilities characterized by perceptual immaturity in spatial orientation and/or temporal organization, but the classical neurological examination administered to them was within normal limits. Ten additional children were classified as having an attention deficit disorder, and 11 additional children were functioning at a borderline level of cognitive ability. Fifty-nine of the 60 children were suffering from diagnosable psychiatric disorders: 21 (35%) severely anxious, 13 (22%) clinically depressed, 12 (20%) conduct disorders, 6 (10%) oppositional, 3 (5%) schizophrenic, 2 (3%) obsessive-compulsive disorder, and 2 (3%) personality disorder. Applications of these findings suggest the need for biological evaluation of problem children and for early detection of children vulnerable to academic failure and emotional disturbances. (Author/CL)

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Children in Classes for the Severely Emotionally Handicapped

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ABSTRACT. This report will describe the clinical findings of a collaborative program to provide appropriate neuropsychiatric skills for 60 children ages 8 to 14 (grade 3 to 8) and their teachers, comprising the entire population of two sef-contained units (eight classes) for the treatment of children designated as severely emotionally handicapped but not autistic. Of the 60 children, 36 (60%) were suffering from learning disabilities. Eighteen of these had neurological signs suggestive of organic defect of the central nervous system; the remaining 18 children with learning disabilities had specific or developmental learning disabilities characterized by perceptual immaturity in spatial orientation and/or temporal organization, but the classical neurological examination administered to them was within normal limits. Ten additional children were classified as having an attentional deficit disorder, and 11 additional children were functioning at a borderline level of cognitive ability. Fifty-nine of the 60 children were suffering from diagnosable psychiatric disorders: 21 (35%) severely anxious, 13 (22%) clinically depressed, 12 (20%) conduct disorders, 6 (10%) oppositional, 3 (5%) schizophrenic, 2 (3%) obsessive-compulsive disorder, and 2 (3%) personality disorder. Applications of these findings are suggested.

Self-contained classes for severely emotionally handicapped children in the public school system have generally suffered from lack of comprehensive evaluation of these children and lack of comprehensive treatment based on these evaluations. This report will describe the clinical findings of a collaborative program involving the Division of Child and Adolescent Psychiatry at University of South Florida Medical School and the Hillsborough County Board of Education. The program was designed to provide appropriate neuropsychiatric skills for 60 children (50 boys and 10 girls), ages 8 to 14 (grade 3 to 8) and their teachers. The group comprised the entire population of two self-contained units (eight classes) for the treatment of children designated as severely emotionally handicapped, excluding autistic children.

A psychiatrist from the Medical School devoted one half day/week during the school year to each of the two self-contained units. During this period, the psychiatrist was responsible for the comprehensive evaluation of each child along a pentaxial scheme (psychiatric, biologic, cognitive, social, educational). The data were transmitted to the teachers in order to collaboratively develop a treatment plan appropriate for each child. The psychiatrist worked with the school staff throughout the year, ensuring that the treatment plan was implemented and modified as needed.

The principle of a mental health component in a school system is not new. In the late 1940s, Gildea[1] offered social services to selected schools in St. Louis. Morse et al.[2] (1964) reviewed the national development of public school classes for the emotionally handicapped. Rhodes and Head[3] (1974) prepared a compendium of service delivery systems for deviant children within the school system.

Comprehensive evaluation of these children, however, is surprisingly scant. Morse[4] suggested that 3% of the total elementary school population was "seriously disturbed," including (a) 6% classified as mentally retarded; (b) 7% as "organic"; (c) 26% as reacting to crises or sustained stress (by depression or loss of self-esteem); (d) 26% as "neurotic" (having internal values and conscience, but who have impulse control difficulty); (e) 27% as "character disorders" ("sociopaths", "psychopaths"); and (f) 8% as psychotic. Quay et al.[5] described a teacher-rated checklist of 441 children in public school classes for emotionally disturbed. Factor analysis of this checklist yields three factors accounting for 76% of the total variance: (1) *conduct problems or unsocialized aggression* (aggressive, hostile, contentious); (2) *inadequacy-immaturity* (lacking interest, sluggish, lazy, daydreaming); and (3) *personality problem or neuroticism* (anxious, withdrawn, introverted). Each group requires different methods of management and teaching.[5]

Several detailed studies of children attending special "psychoeducational" day treatment centers have been described.[6-9] A survey was conducted of 67 children, in treatment at a day treatment center located within a psychiatric clinic in Denver, Colorado during the period from 1962 to 1970. The data revealed that boys out-

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numbered girls 3.5 to 1, 25% were nonwhite, 30% were in the lower socioeconomic group, and 33% had parents who were divorced, separated, remarried, or who had deserted. Diagnostic categories included: 24% "developmental deviations," 18% character disorders, 18% hyperactive syndrome, 18% phobic inhibition, 10% borderline psychosis, 9% depressed, and 3% anxiety reactions. Twenty percent of the total, exclusive of psychiatric diagnoses had neurological dysfunction. Details and overlapping of the diagnostic categories for each child were not presented.

This report describes findings of 60 children attending special classes in two units for severely emotionally handicapped (SEH) children in a public school system. One unit in the heart of the city contained four classes, housed in a wing of a large school serving educable mentally retarded children in addition to the severely emotionally handicapped. The other unit, on the fringes of the city, contained three classes housed in portables, but physically a part of a large school for 1200 "normal" children. Grades in the special classes ranged from 3rd through 9th (age 8 to 16). The 60 children included 50 boys and 10 girls. In order to have been placed in the SEH classes, the child had to have failed in other less restrictive programs in the school system. Evidence of failure included: (1) after receiving supportive educational assistance and counseling, the child still exhibited severe emotional handicaps (as determined by documented observation and psychological testing) over an extended period of time; (2) behaviors which disrupt the student's own learning, reading, arithmetic, or writing skills, social-personal development, language development, and behavioral control; and (3) the problem cannot be attributed primarily to physical, sensory, or intellectual deficits. Each child in the program was studied by a neuropsychiatrist. The pentaxial evaluation used in this study is an individual examination of each child:

1. *Psychiatric evaluation.* An appraisal of the content of the child's thoughts and feelings, the psychodynamic problems with which he may be struggling, the structure and developmental level of the child's personality, and the genesis of the deviation.

2. *Biological evaluation.* A classical neurological examination that includes identification of soft neurological signs; delay in developmental parameters in postural responses, kinetic and attentional patterns; body image maturation as seen in praxis, finger gnosis, right-left discrimination; indices for hemisphere specialization; perception in all modalities; intersensory integration; language in its receptive, associative, and emissive aspects; stability and lability of the autonomic nervous system; ectodermal defects. Laboratory examinations such as EEG, CAT scan, and examination for abnormal metabolites were performed when indicated.

3. *Psychological evaluation.* In general the child referred for special help has already had at least one psychological examination, including as a rule a standardized test of overall cognitive function, tests for visual motor function, language tests, and projective tests. Frequently serial testing over three or more years is available.

4. *Environmental-Social evaluation.* An important part of the total evaluation is to determine the current reality of the child's home; an evaluation of parents and siblings and their interaction with the child; past social history in order to understand the stresses and supports to which the child has been exposed; an assessment of the appropriateness of the stimuli to which the child had been exposed at crucial ages in development; and the capacity of family and environment for change.

5. *Educational assessment.* The child referred for special SEH help has had a past educational history documented as to behavior and educational achievement.

Results of these examinations are recorded in Tables 1 to 4. Table 1 categorizes the neurological and cognitive components; Table 2 identifies more precisely the variety of etiological factors probable in those children categorized as having an organic CNS defect; Table 3 utilizes DSM III categories for psychiatric diagnosis; and Table 4 describes the various combinations of disorders seen in each of the 25 children of one of the units.

Table 1 reveals that 46 of the 60 children (77%) have some defect at the biological level. This includes children with Attention Deficit Disorder, organic CNS

TABLE 1. Self-Contained Classes for Severely Emotionally Handicapped (Neurological and Psychological Component)

Predominant Diagnosis	Seffner N	Manhattan N	Total N	Total %
Attention Deficit Disorder	5	5	10	17
Organic CNS defect	10	8	18	30
Specific learning disabilities	6	12	18	30
Schizophrenia	1	2	3	5
Borderline mental retardation	3	8	11	18
Total	25	35	60	100

TABLE 2. Self-Contained Classes for Severely Emotionally Handicapped

Variety of Neurological Disease Found (Seffner and Manhattan Schools)	
Prematurity*	3
Cerebral palsy	3
Genetic (chromosome defect)	3
Seizures, idiopathic	2
Cerebellar palsy	2
Rh incompatibility	1
Tourette's syndrome	1
Unknown dyskinesia	1
Pb toxicity	1
Birth trauma	1
Total	18

* One with fetal alcohol syndrome.

TABLE 3. Self-Contained Classes for Severely Emotionally Handicapped

Results of Comprehensive Evaluation (Psychiatric Component)				
Predominant Diagnosis	Seffner N	Manhattan N	Total N	Total %
Anxiety disorder	7	14	21	35
Depressed	7	6	13	22
Conduct disorder	4	8	12	20
Oppositional disorder	2	4	6	10
Schizophrenia	1	2	3	5
Obsessive-compulsive disorder	2	0	2	3
Personality disorder	1	1	2	3
No psychiatric diagnosis	1	0	1	2
Total	25	35	60	100

defect, and specific learning disabilities. These children have structural, physiological, or functional problems relating to the central nervous system which presumably are not due to psychogenic causes. If schizophrenia and borderline mental retardation are regarded as defects at the biological level, then all 60 children (100%) have some biological defect. The nature of this defect, however, is extremely variable. Eighteen of the 60 (approximately 33%) are considered specific learning disabilities (SLD). These children, with average intelligence and with adequate educational exposure, have severe problems in spatial orientation and temporal organization which may be seen in all varieties of perceptual and intermodal integration defects.[10, 11] The 18 children with SLD are those who do not have evidence of structural defect of the central nervous system or Attention Deficit Disorders. Children with attentional defects (17%) and those with organic defects (30%), however, may also have learning disabilities, suggesting that learning disability (LD) may be found in 20 of 25 children in the suburban SEH school classes and in 21 of the 35 SEH children at the inner city school. A total of two-thirds of the children in the SEH classes had learning disabilities.

The children designated as organic CNS defect (approximately 33%) present special problems. They exhibit variable etiologies (Table 2) and a wide range of symptoms. Three of the 18 children were prematures (weighing less than 3 lbs. at birth). Three had mild hemiparesis and represent cerebral palsy; three had genetic aberrations (one trisomy 21, one mosaic trisomy 21, one Treacher-Collins syndrome); two had idiopathic grand mal seizures; two had problems with motor synergy, equilibrium and nystagmus; and one each with history of Rh incompatibility, Tourette's disease, dyskinesia of unknown etiology, lead toxicity, and history of traumatic and anoxic birth. One of the premature children (D.F.) also suffered from fetal alcohol syndrome. As a group, these children appeared more vulnerable to anxiety[12–16] and less able to tolerate change than the nonorganic groups. In addition, however, they have specific characteristics in response to their specific areas of defect. The children with cerebral palsy, for example, are generally fearful of heights, resistant to changes in equilibrium, clinging with adults, demanding, infantile in behavior, have difficulty in body image perception or in fine motor coordination. Their behavior could not be controlled by behavior modification alone. Educational training had to be directed at their specific defects, but learning had to be channeled through their intact perceptual areas. The awareness of their organic deficits offered the staff a new dimension of understanding and new approaches to educational management.

The total number of children with Attention Deficit Disorder appeared small, in contrast to the reported incidence of this disorder.[17] Only one of the children required methylphenidate (R.T.); another (T.J.) had associated depression and responded to imipramine. The remainder of the group responded well to educational success and reduction of their associated perceptual defects and learning disabilities.

Of the three children felt to be schizophrenic, only one floridly psychotic child (G.G.) required Haldol. The remaining two appeared to respond to strong supportive help.

Psychiatric examination revealed a spectrum of disorders and emotional disabilities. It is most difficult to condense the variegated individual symptoms of emotional disorder and reaction to experiential stress into the Axis I and Axis II categories of DSM III; recognizing that even within categories the individual symptoms are multiple and varied, Table 3 provides an outline of the major categories found. Twenty-one of the 60 children (35%) manifested overt anxiety.

CASE REPORTS

Donald is an example of separation anxiety. He is 11½ years old; he makes every effort at being liked, needing reassurance, physically holding on to the examiner's arm and clinging. He has persistent dreams of monsters which "grab you" and "try to get a knife into you" and "cars running over you." He is preoccupied with worry that his foster mother will be killed. He is afraid to be home alone at night and needs a night light so that "no one can come in through the windows." He becomes restless and fearful when he thinks of being rejected from his foster home. On neurological examination, Donald (D.F., Table 4) was a small 11 year old, appearing no older than 9 years of age. He is mildly dysplastic with malar hypoplasia, narrow palpebral fissures, and microphthalmia of the right eye. Major findings include (1) gross, coarse intention tremor; (2) nystagmus on lateral gaze; (3) brisk deep reflexes with transitory ankle clonus bilaterally; (4) primitive visual-motor function; (5) immature auditory sequencing, auditory recall, and vocabulary at about a 9 year age level—in a child who had been abandoned by his parents and had been in seven foster homes. His overall intellectual function was borderline. History was consistent with a diagnosis of fetal alcohol syndrome.

Leo, age 9½, is classified as exhibiting an overanxious disorder. He also has anxiety dreams in which sharks "almost" eat him. He fears that his mother could die and he cannot protect her. He is very much aware of his worries, needs constant reassurance, but is still concerned that he cannot cope with the world. He believes that some of his academic

TABLE 4. Seffner School (1981–1982): Results of Comprehensive Evaluation—Predominant Diagnoses

Patient	Biological	Psychological	Cognitive	Environmental
C.A.	Organic anoxia LD	Overanxious disorder; sadomasochistic	Low average	Sadistic father
R.A.	LD	No psychiatric diagnosis	Borderline MR	Sibling retarded
P.B.	ADD + hyperkinesis	Overanxious	Average	Parents separated; mother works nights
J.B.	Organic (dyskinetic) LD severe	Depressed	Low average (V 80, P 98)	Mother alcoholic, abusive, 3 marriages
E.B.	SLD	Conduct disorder; socialized aggressive	Low average	Father left when patient was 3 years; mother involved with "boyfriends"
R.C.	Organic (prematurity) LD; abnormal EEG	Depressed	Borderline	Adopted
J.E.	Tourette's syndrome	Overanxious	High average	Had been treated with varied medication
D.F.	Organic (prematurity); fetal alcohol syndrome; LD	Overanxious	Borderline	7 foster homes; abandoned by parents
S.H.	Organic (cerebellar) LD	Immature, dependent, "affect hunger"	Low average	Mother punitive and rejecting; frequent marriages
G.G.	SLD severe	Schizophrenic	Borderline	Brother schizophrenic
T.J.	ADD + hyperkinesis	Depressed; identify problem	High average	Never knew father
L.H.	Organic (etiology?) SLD	Overanxious	Low	Toxemia of pregnancy; left-handedness in family
S.J.	ADD; SLD	Oppositional	Average	Adopted; rigid home
C.J.	Organic (prematurity) LD	Depressed, sadomasochistic traits	Borderline	Father aggressive
E.J.	ADD + hyperactivity; Pb toxicity; LD	Depressed	Low average	Death of mother and grandfather; father left; cared for by grandmother; overindulged
J.K.	ADD + hyperactivity; SLD severe	Overanxious	High average	Enuresis; sleep-walker
T.M.	SLD	Depressed	Low average	Parents separated
S.M.	Organic CP; seizure disorder; LD	Obsessive-compulsive	V 66, P 103	Adequate home
E.S.	Organic (etiology?) SLD	Conduct disorder; socialized unaggressive	Borderline	Rigid household; school demanding
C.S.	SLD	Obsessive-compulsive	Superior	
M.T.	SLD	Overanxious, depressed	Low average	Recent death of mother; blames himself
R.T.	ADD hyperkinesis; SLD	Conduct disorder; socialized unaggressive	Average	Parents separated; mother concerned and in therapy
L.W.	No organic diagnosis	Conduct disorder; socialized unaggressive	Mild retardation	
B.W.	No organic diagnosis	Depressed, withdrawn	Mild retardation	Parents separated
J.Y.	SLD	Oppositional	High average	Father childlike and destructive; mother passive

problems are the result of his past bad behavior. Leo, however, like Donald, has signs suggestive of structural defect of the central nervous system (Table 4, L.H.). Significant problems on neurological examination include poor gross and fine motor coordination and motor impulse control, difficulty with equilibrium, a persistence of neck-righting reflexes, nystagmus on lateral gaze, poor motor synergy, and marked synkinesis. Perceptual examination revealed impaired visual-motor function and praxis. EEG is described as abnormal with diffuse high voltage slow waves. This child was referred as suffering from a hyperkinetic attentional defect disorder. Neurological findings, however, suggest that there is an underlying structural organic CNS affect, nonprogressive, perhaps associated with the severe toxemia during his pregnancy. His family is intact.

John (J.K.), age 8½, deals with his anxiety in other ways. He creates cartoons in his mind, hears music, creates dialogue. The "cartoons" are anxiety situations in which he tries to have power, "the power of Jesus." He has auditory hallucinations. He has regressed with soiling. Behind these symptoms are pools of anxiety. Neurological examination revealed an alert, active 8½ year old boy, who makes an immediate trusting relationship with the examiner. He has a press of speech, a constant chatter, most of which was relevant and well articulated. He has a perioral pallor, rapid heart rate and motility which may be termed choreiform. Classical neurological examination was within normal limits. He does have marked difficulty with praxis and finger gnosis and tends to displace single tactile stimulus to bilateral symmetrical stimuli. Visual-motor function was impulsive and uncontrolled; auditory temporal sequencing was impaired. John has an Attention Deficit Disorder, and although his WISC-R full scale IQ is 113 (V = 103, P = 123), his reading level was at beginning first grade (Wide Range). He has the characteristic spatial and temporal disorganization of a specific learning disability.

Thirteen of the 60 children are clinically depressed. *Rondal*, for example (R.C., Table 4), age 13, comes into the examination room saying "life is miserable." He feels people "bug him," that he has severe acne (really mild), and his teeth are terrible (again not bad). He feels small and inadequate, that he will never succeed, and that no one will ever love him. He might just as well, he says, "jump off the roof." Rondal has a severe learning disability. He has a problem finding words to express his thoughts, and he becomes thoroughly exasperated when he cannot convey his ideas. He was premature at birth, with birth weight less than 3 lbs.; he was adopted by caring parents at 6 weeks of age. Neurological examination reveals a small, physically immature 13 year old with a persistent fine tremor even at rest but increased on intention. He has marked synkinesis. His mouth pulls to the right. Fine motor coordination is very poor. He has difficulty with fine motor coordination, in finger gnosis, in rote sequencing and in visual-motor function. EEG is abnormal, with epileptogenic focus in the left temporoparietal area.

Troy (T.J., Table 4), age 12 years, also depressed, is considered hyperactive. Although he functions cognitively at a high average level, he does not do his academic tasks, sulks, and gets into arguments with teacher and peers. He has never known his father, never seen a picture of his father, and now at beginning adolescence, blames his mother and the world for the father he has never had. Classical neurological and perceptual examinations are within normal limits.

The anxious and depressed children account for more than one-half of the children attending these special classes. Conduct disorders account for an additional 20%. These are children mostly in the lowest socioeconomic groups with extremely disruptive families and with aggression being the usual behavior in their world. An additional 10% are classified as "oppositional." *Justin* (J.Y., Table 4) is an example of such a child. He is cognitively bright, an appealing blond, brown-eyed, 8 year old. He has specific visual-motor immaturities, but he will argue at every task, digging in his heels, and wanting to do everything his way. There are occasional dramatic temper outbursts. Neurological examination is within normal limits. His father says he was just like his son, and indeed he *is* just like his son, domineering, argumentative, but also belittling his wife and his son. Justin's mother, on the other hand, is passive and submissive.

Three children (5%) were considered schizophrenic. One (G.G.) is psychotic; the remaining two, bizarre in thought and behavior, demonstrated problems in reality testing. Two children (3%) had developed obsessive-compulsive disorders. One of these (S.M.) had a mild left hemiparesis, a history of seizures, and a verbal IQ of 66 on the WISC-R compared to performance IQ of 103; the other (C.S.) had a specific learning disability, with cognitive abilities in the superior range (WISC-R FS 123, V 120, P 123).

DISCUSSION

The data obtained from the comprehensive pentaxial study provide an overview of the nature and extent of the problems which children bring into the self-contained classes for severely emotionally disturbed children. The incidence of organic defects of the CNS (30%) stresses the need for biological evaluation of problem children. It will be noted that Blom et al.[6,7] found that 20% of their population had "neurological dysfunction." The persistence of specific learning disabilities (30%) is comparable to the incidence found by Blom et al. to have "developmental deviations" (25%). Children with Attention Deficit Disorder (17%), one or two in each class, were *not* a numerically large number. Psychiatrically, most of the children had already internalized intrapsychic problems (35% anxiety, 22% depression, 3% obsessive-compulsive), suggesting that behavior modification alone may not be sufficient for their needs.

With data obtained from these examinations, the administrator of programs for the severely emotionally handicapped may then prepare rationally, rather than intuitively, for the total class needs. Equally important, however, is the understanding that such evaluation offers for each individual child. The child is seen not only as a problem child with problem behaviors, but a multifaceted personality, the dimensions of which may be understood so that appropriate therapy may be introduced. Behavior modification so prevalent in educational models, although useful, will alone not meet the needs of children with specific learning disability, the overanxious child, the child with organic CNS defects, the depressed or the obsessive-compulsive child. With data from a comprehensive evaluation, all forms of therapy and education may appropriately be devised in the individual therapeutic-educational plan.

These data are also important in prevention. Ideally, the comprehensive diagnosis should *not* wait until repeated failure has occurred, intensifying the emotional

problems, the self-doubt, the anxiety, and resulting behavior disturbance. Children vulnerable to academic failure and emotional decompensation may be detected as early as kindergarten (or as late as first grade) and treatment introduced before failure has occurred.[18] Early remediation, before failure, has decreased the incidence of emotional and conduct disorder by the 5th grade even in the underprivileged population.[19]

CONCLUSIONS

Comprehensive evaluation, involving individual psychiatric, biological, cognitive, social, and educational evaluations of 60 children comprising the entire population of two self-contained day care units for treatment of severely emotionally handicapped children (SEH) within the public school system was performed. Data revealed that 33% suffered from specific learning disabilities, 33% had evidence of structural defect of the central nervous system, 17% had Attention Deficit Disorders, and 18% were borderline mentally retarded. Psychiatrically, slightly more than 33% of these children were classified as anxiety reaction (DSM III); 22% were depressed. Twenty percent, largely children from lower socioeconomic groups, exhibited conduct disorders of various types; 10% were considered oppositional (DSM III). There were three children with schizophrenia, two were considered obsessive-compulsive, two with personality disorder (one immaturity, the other with little superego development), and a child who was cognitively retarded but who appeared to have no psychiatric disorder.

These data may be used for understanding the overall problems to be cared for in the SEH classes, and for understanding the multifaceted problems with which each child struggles. The therapeutic needs of the entire class may thus be based upon hard data and the individual therapeutic educational plan for each child appropriately determined. Early detection and management may prevent serious emotional sequelae.

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